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APR 25 2002

STATEMENT OF ADMIRAL JAMES M. LOY, COMMANDANT OF THE COAST GUARD, REGARDING THE ADMINISTRATIVE INVESTIGATION OF THE 23 MARCH 2001 STATION NIAGARA BOAT MISHAP

Today I signed the final action on the administrative investigation into the boat mishap and the resulting deaths and injuries to Station Niagara crewmen that occurred on 23 March 2001. This accident claimed the lives of two crewmen from Station Niagara: Petty Officer Second Class Scott J. Chism and Seaman Christopher E. Ferreby.

Before commenting on the investigation, I once more extend my deepest sympathies to the families of these Coast Guardsmen, and assure them that their loyal and dedicated service will always be appreciated by the United States Coast Guard.

In the citation accompanying the Coast Guard Medal awarded posthumously to Petty Officer Chism and Seaman Ferreby, their bravery and professionalism were acknowledged and highlighted. Service with the Coast Guard is about commitment and dedication to protecting and saving lives. Petty Officer Chism and Seaman Ferreby personified these ideals in a manner that represents the highest traditions of the United States Coast Guard.

Our initial safety investigation into this mishap was released in February 2002. The current administrative investigation is a broader effort that examines potential servicewide issues as well as specific details about the mishap.

The administrative investigation found a number of systemic shortcomings that reduced the margin available for human error. A summary of the report and its findings are attached. However, I will briefly refer to the major factors and recommendations I identified. The investigation indicated that the deaths resulted from a series of equipment and experience shortfalls, as well as a number of mistakes made by people on the water and ashore. As a result of this investigation, I have mandated new equipment, improved training programs, and revisions to certain policies and procedures.

Regardless of the circumstances, the sacrifice these men made, and that which other men and women have made while serving with the United States Coast Guard, will always be appreciated and never forgotten. They cared for the safety and welfare of others, and nothing is more noble.

JAMES M. LOY
Admiral, U.S. Coast Guard
Commandant

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Subj: FINAL ACTION ON THE ADMINISTRATIVE INVESTIGATION INTO THE BOAT MISHAP AND THE RESULTING DEATHS AND INJURIES TO STATION NIAGARA CREWMEN THAT OCCURRED ON 23 MARCH 2001

1. Overview: On the evening of 23 March 2001, CG-214341 capsized in Lake Ontario near the mouth of the Niagara River while conducting a law enforcement patrol. The four Coast Guard crewmembers, outfitted in dry suits, entered the 36-degree waters of Lake Ontario where they remained for approximately four and one-half hours until they were located and recovered by a local fire department vessel assisting the Coast Guard search effort. Two of the crew were treated for hypothermia and released from a hospital after approximately 36 hours. Tragically, the remaining two crewmen were recovered with no vital signs and were pronounced dead after extensive efforts at revival.

This document adopts the facts herein contained, states my conclusions, and orders certain actions designed to ensure that similar incidents and other tragic losses of life are avoided in the future.

The facts and conclusions indicate we need to improve performance and eliminate the shortfalls that led to this tragedy. Our lost shipmates have sounded a danger signal. We must heed their sacrifice with renewed commitment to steer a safe course.

2. Findings of Fact:

The 170 enumerated findings of fact made by the Investigating Officer, as modified by the Supplemental Investigation, as well as in review by the Convening Authority (Ninth District Commander) and the Intermediate Reviewing Authority (Atlantic Area Commander) are expressly adopted.

The following narrative summarizes key findings that informed my Final Actions:

On 23MAR01, Station Niagara's 41-foot Utility Boat (UTB) was out of the water, due to ice conditions. The Station was operating CG-214341, a 21-foot foam collar boat that the Ninth District Commander judged to be rated for a maximum of 4-foot seas. CG-214341 had a history (which was known to the junior members of Station Niagara) of being susceptible to burying the bow. Additionally, when the boat was new it was discovered to not be positively or neutrally

buoyant when it sank at the dock during a dewatering drill. Subsequent to the sinking, the manufacturer added over 45 cubic feet of foam to the bow void and to the fuel cavities beneath the deck plates of CG-214341 as a no-cost retrofit to correct this problem. These facts were known by BM2 Chism, the coxswain, the night of the mishap. With 17 months as a designated coxswain and 3 years and 7 months total service, BM2 Chism was considered to be the most experienced and proficient coxswain at the station, aside from the Officer In Charge (OinC) and the Executive Petty Officer (XPO).

CG-214341 departed Station Niagara for a law enforcement (alien interdiction) mission on the Niagara River at 1941 on a cold, dark night, with BM2 Chism, MK3 Moss, MK3 Simpson, and SN Ferreby aboard. The air temperature and water temperature were both under 40 degrees Fahrenheit. The crew wore dry suits, but BM2 Chism wore a comfort ring that kept the neck seal of his suit open and allowed the suit to ventilate. SN Ferreby wore cotton undergarments, as did MK3 Simpson, contrary to the provisions and warnings of the Rescue and Survival Systems Manual which prohibits cotton garments as the foundation layer because they retain moisture and accelerate hypothermia. Of the four crew members, only MK3 Simpson wore a boatcrew survival vest, although all four were required by regulation to wear this vest, which contains flares and other emergency signaling equipment. BM2 Chism briefed the Station Niagara communications watch stander and XPO, who was also the Acting OinC, that he intended to patrol the river. However, BM2 Chism took CG-214341 out onto Lake Ontario very soon after getting underway. At the mouth of the river, the winds were about 10 knots and waves were 4 feet. The Coast Pilot describes the river current at over 2 knots, though some crew members at Station Niagara believe the local currents to be as high as 6 knots.

Having rounded buoy "3", the boat was headed back toward the river when the bow of the CG-214341 took on water, causing the boat to pitch pole and begin to capsize. BM2 Chism instructed the crew to jump. Shortly before 2000, the crew entered the water as the boat capsized. BM2 Chism instructed them to stay clear of the boat, fearing they would be caught or sucked beneath the water when the boat sank. The boat did not sink, but due to differing drift rates and current, the crew was unable to reach it or a nearby buoy. BM2 Chism instructed the crew to huddle together to conserve body heat.

Apart from the radio in the boat, and a cell-phone that was not used, there were no means of communication with Station Niagara. As noted above, only one of the four wore a boatcrew survival vest. The strobe light in that vest flashed only 10-12 times a minute (once every 5-6 seconds) and soon slowed to once or twice a minute, instead of the 50-70 flash per minute rate required by the equipment specification. This was probably due to weak batteries, as they had not been changed as required in the October 2000 semi-annual inspection. The crew was not able to use the pen flare kit in the vest in spite of several attempts (later testing ashore indicated that it was damaged). Both ends of the MK 124 flare from the one boat crew survival vest were successfully lit. Additionally, the crew fired their side arms into the air in hopes of attracting

attention. There was no response to any of the signals. Help arrived at approximately 0030 on 24MAR01.

When the Station Niagara communications watch stander did not receive a position / ops normal report from the CG-214341 at 2000, he attempted to contact the vessel by radio, cell phone, and through Group Buffalo communications, all without success. When CG-214341 missed a second consecutive 30-minute position/ops normal check at 2030, the seaman watch stander called the XPO/Acting OinC, a first class boatswains mate. The XPO/Acting OinC chose to not "hit the panic button," and undertook to personally search for the boat along the riverbanks while he was en route the station. Although required to notify the Group and District at this time (second missed report), the XPO/Acting OinC directed the watch stander to alert Group Buffalo if nothing was heard from the CG-214341 by 2130, an hour later. As directed, the watch stander, having heard nothing from the CG-214341 by 2130, called and briefed the Group and recalled the (actual) OinC. This was 90 minutes after the first missed report. Shortly after 2200, the Station networked with the local sheriff's department for helicopter assistance and with local fire departments for boat searches, using additional Station crew recalled by the OinC. The XPO returned to the station after unsuccessful shoreline searches, took a radio and night vision goggles and resumed his shoreline search. He returned around 2300, at which time he and the OinC conferred and agreed that the search ought to be expanded out into Lake Ontario.

Meanwhile, the Group Duty Officer had arranged for a Canadian helicopter to search, following completion of a mission the helicopter already had in progress. Group Buffalo contacted and briefed the Ninth District Command Center at 2201, two hours after the first missed report. The District Controller did not begin briefing the incident to his chain of command until just before 2300, three hours after the first missed report. In the second of three serial briefs, around 2308, the district controller was directed by the District chief of operations to get an Air Station Detroit helicopter on the case. At the chief of operations' direction, the controller located the District Commander, added him to the conference call and briefed the case until approximately 2330. At 2334, three and one half hours after the first missed report, the Air Station was directed to launch. Helicopter CG-6511 was airborne en route twenty-one minutes later. Less than an hour and a half after notice, helicopter CG-6511 was on scene (equipped with night vision goggles). However, by the time CG-6511 arrived on scene at 0102, the missing boat crew had already been recovered by a local fire department boat.

The crew of CG-214341 entered the 36-degree water prior to 2000. Having swum away from the capsized boat and found they were unable to swim back to it, the crew huddled together. Within 45 minutes, effects of hypothermia were apparent. MK3 Moss was found first and had been in and out of consciousness when rescued roughly 4 ½ hours after entering the water. BM2 Chism had lost consciousness and drifted away. Water had infiltrated his dry suit through the comfort ring to such an extent that it caused him to sink beneath the surface while unconscious and made it difficult to retrieve him from the water. He was in cardiac arrest when recovered by the

fireboat. SN Ferreby, the smallest of the crew at 140 pounds, lost consciousness and drifted away as well. He was recovered without any head covering (although he departed the Station with balaclava headgear) and with damp cotton underclothing. SN Ferreby was also found in cardiac arrest, bobbing on the surface. MK3 Simpson was recovered in the best shape of the four, but, like MK3 Moss, required rewarming and observation for over a day in the hospital before being released.

BM2 Chism and SN Ferreby were pronounced dead after extensive efforts to rewarm and revive them. Both died from asphyxia due to drowning. Though they had been wearing Type III personal flotation devices, this standard equipment provides only 15.5 lbs of buoyancy and will not ensure that an unconscious person remains face-up in the water. Hypothermia rendered both BM2 Chism and SN Ferreby unconscious and led to their deaths by drowning.

3. Findings and Directed Action:

Opinions and Recommendations and Comments of the Investigating Officer, Convening Authority, and Intermediate Reviewing Authority: Unless contained in the text of this Final Action, I do not expressly or implicitly adopt the opinions, recommendations and comments expressed by the investigating officer, nor those of the reviewing authorities. As such, their work and comments remain deliberative documents, the release of which (external to the U.S. Coast Guard) would have an unacceptable "chilling effect" on the candor of full and frank input necessary in decision-making, may unnecessarily cause confusion in the public, or both. The deliberations of the Investigating Officer, Convening Authority, and Intermediate Reviewing Authority, which I considered in deciding my Final Action, are consolidated in Exhibit D, which represents deliberative information protected from public release under a Freedom of Information Act exemption.

This Final Action Letter with Exhibits A, B and C may be released. However, it shall be released first to the families of BM2 Chism and SN Ferreby prior to any further distribution. The 170 findings of fact made by the Investigating Officer are Exhibit A. Those findings are supported by 68 enumerated enclosures. Exhibit B lists material in the 68 enclosures that is being withheld from release, either wholly or in part ("redacted"), pursuant to Freedom of Information Act exemptions. Exhibit C is the releasable material from the 68 enclosures and includes a Table of Contents. Exhibit D contains the deliberative documents mentioned in the preceding paragraph, as well as any other documents exempted from release by the Freedom of Information Act.

A. I find that the deaths of BM2 Chism and SN Ferreby were preventable.

These deaths were doubly tragic as they resulted from a series of mistakes, system shortcomings and human error, any one of which, had it not occurred, may have allowed both men to survive.

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B. I find that, although the crew of CG-214341 were qualified for their duties, their conduct indicates that they were not adequately trained, or had not appropriately internalized the training.

I base this upon the crew's:

- Failure to inform the station of their deviation from their intended patrol route.
- Failure to be properly dressed - some wore cotton undergarments that accelerated hypothermia, and one wore a "comfort ring" at the neck that rendered his anti-exposure suit ineffective.
- Failure of three crewmen to wear boat crew survival vests, reducing by 75% the emergency signaling equipment available.
- Swimming away from their best chance of survival, their overturned boat.

The reasons for these fatally flawed behaviors undoubtedly involve failures by:

- The crew to understand and/or adhere to standards and best practices.
- The chain of command at all levels to leverage the best practices of others, enforce standards and provide sufficient training and skill development for small boat operations.

Action: As a result of this finding I direct:

- The Assistant Commandant for Operations to increase emphasis on the portion of biennial standardization assessments that deals with use of protective equipment and survival techniques. Standardization Assessment reports shall contain a section devoted specifically to PPE quantity, quality of maintenance and use.
- The Assistant Commandant for Human Resources to examine our service-wide boat crew protective equipment and survival technique training programs, and identify the appropriate times in members' careers and assignments when the training, and training/policy reviews should occur. Working with the Assistant Commandants for Operations, Marine Safety & Environmental Protection and Systems, modify current programs and create new programs as needed so as to ensure boat crews are properly trained and refreshed in policy and procedures. Such training shall specifically emphasize the importance of adhering to policies pertaining to the filing and following small boat operations patrol plans, including reporting requirements for deviations from filed patrol plans.
- All Commanders, Commanding Officers and Officers in Charge with operational responsibility for small boats and/or coastal command & control centers to place greater emphasis on adherence to standards and professional conduct of missions at every opportunity. Specifically:
    - Commanders, Commanding Officers and Officers in Charge with operational responsibility for small boats and/or coastal command & control centers shall ensure that appropriate policies pertaining to the filing and following of small boat

operations patrol plans are in place for their units, including adequate reporting requirements for deviations from filed patrol plans.

- Commanders, Commanding Officers and Officers in Charge with operational responsibility for small boats and/or coastal command & control centers are to reinforce the use of Operational Risk Management (ORM) and Team Coordination Training (TCT) techniques on a daily basis. This should include regular examination of unit operations, discussion of case studies, and inclusion in mission planning sessions, as well as ensuring that biennial ORM/TCT training requirements are met with quality, effective events.
- Activities and Group Commanders are to focus on the quality and conduct of their Ready for Operations (RFO) programs. RFOs must be conducted at each station each year. During years in which a biennial standardization assessment is also scheduled, it is helpful to conduct RFO assessments a month or two in advance of the standardization assessment. This helps both the unit prepare and the Activities/Group Commander evaluate RFO effectiveness.
- District Commanders receive and should personally review Standardization Assessment reports. These provide a wealth of information about unit readiness and support required from outside the unit. All too often these reports cite boat and unit discrepancies that have been carried forward from year to year.
- District Commanders should schedule an event or program during the year to focus themselves and their staff on the quantity and quality of boat operations. These events should include reviews of service-wide mishaps, standardization assessments, resource and training needs that have come to light, etc.

C. I find that the normal boat tracking and mission monitoring process failed. This failure resulted from:

- The watchstander's inability to detect the coxswain's deviation from intended track.
- Shortcomings in established procedure.

I base this finding upon:

- The boat was expected to patrol in the Niagara River, but was actually operated in Lake Ontario unbeknownst to the watchstander responsible for monitoring its progress and safety.
- The reporting interval of 30 minutes in use was insufficient for the existing conditions (night, cold, lack of back-up boat).

Action: As a result of this finding I direct that:

- The Assistant Commandant for Operations to ensure that boats provide the unit maintaining their radio guard a "float plan" and that they notify the guarding unit of any significant changes in their projected movements.

- The Assistant Commandant for Systems and the Assistant Commandant for Operations revise service-wide radio guard and lost communications procedures for boats. The revised procedures shall include reduced reporting intervals for missions conducted in conditions that pose greater risks to crews.
- The Assistant Commandants for Operations, Acquisitions, and Systems ensure that automated asset tracking for station boats is provided as a part of the National Distress and Response System Modernization Project.

D. I find that the crew had inadequate means of communicating their emergency and position.

I base this finding upon:

- Only one set of pyrotechnic devices for the four crewmen (see finding B, above).
- Reliance on the boat's installed radios for emergency electronic communication. Without hand-held radios, EPIRBs or other such device, the crew was in an all-or-nothing situation with respect to electronic communications. Any number of electrical malfunctions or failures (such as the boat capsizing in this case) can disable a boat's installed radios and leave a crew without communications.

Action: As a result of this finding I direct:

- The Assistant Commandant for Operations to ensure that some method of automatic distress and position signaling for boats and/or their crews is implemented in FY-02. This capability shall be maintained until it is replaced by automated asset tracking incorporated into future command and control systems.

E. I find that the response to the loss of communication with CG 214341 was inadequate and evidenced complacency among many watchstanders.

I base this finding upon:

- The XPO/Acting OINC acted against procedure and improperly directed a delay in notifying the Group duty officer. This unwillingness to "hit the panic button" significantly delayed a proper SAR response.
- The Station and Group's failure to include portions of Lake Ontario in the initial search areas, given the known river current and the time lapse since contact with the boat.
- The District controller failing to brief his chain of command concerning the case for almost an hour.
- The District controller not launching a USCG helicopter response as soon as he became aware of the case, and by delaying launching the helicopter more than 30 minutes after he was directed to do so. The helicopter was eventually directed to launch more than 90

minutes after the District controller became aware that the boat had already been "lost comms" for and hour and a half.

Action: As a result of this finding I direct:

- The District Commander to inquire into the conduct and qualification of the Station XPO and District controller.
- The Assistant Commandant for Human Resources to develop a case study based upon this mishap and use it as widely as possible in appropriate Coast Guard training programs.
- District Commanders to ensure that units and all echelons of command regularly exercise lost communications/ lost boat procedures. The above-mentioned case study and similar scenarios should be used in these exercises.

F. I find administration, supervision, support and training for our large fleet of shore based "non-standard boats" is inadequate.

This finding is based upon a number of facts revealed in this investigation including:

- CG-214341, and three identical boats, were purchased and placed into service in spite of the fact that they were open boats not positively or neutrally buoyant.
- The District and unit were not aligned as to which boat class (RIBM, UTL, etc.) CG-214341 represented and its operational limits.
- There is no apparent methodology for determining the appropriateness of a particular non-standard boat for an environment or application, or for modifying non-standard boats.
- In spite of several "near misses" where the boat shipped water, buried the bow, and at least one instance of a member ejected from the boat, the Station OINC and District boat manager were not aware of these incidents nor any concerns with the boat's performance.
- There is no formal training program, or even service-wide guidance, for operation of non-standard boats which are typically small, fast and highly maneuverable. The coxswain had experienced difficulty handling this boat before, but apparently believed his "porpoising" technique was appropriate. The investigation was unable to refute or support this contention based upon Coast Guard policy, guidance, training standards or doctrine.

Action: As a result of this finding I direct:

- All Area and District Commanders to publish operating limits for each of their non-standard boats and to re-examine the suitability of each boat for the role in which it is employed.
- Area commanders to establish non-standard boat coxswain training programs in FY-02. The Assistant Commandant for Operations will coordinate and assist with requirements for additional resources. The Assistant Commandant for Human Resources shall assist

with course development and implementation, and include provisions for this kind of training in the Boat Operations Training Plan now under development.

- District Commanders to ensure that crews are adequately trained on the specific boats they operate and have sufficient operational guidance. I note that the Assistant Commandant for Operations promulgated the Non-Standard Boat Operator's Handbook (COMDTINST M16114.28) on 03 April 2002; it is available on the Commandant (G-OCS) web site.
- The Assistant Commandant for Systems to develop a process for District Commanders to use to ensure the safety and appropriateness of modifications to non-standard boats.
- The Assistant Commandant for Operations to continue, and accelerate where possible, efforts to replace non-standard boats with a fleet of standard boats with clearly defined operating parameters, specifically selected to meet service needs, and which are supported through their life cycle by the expertise of Coast Guard naval engineers.
- All District Commanders, Group Commanders, Commanding Officers and Officers in Charge to re-emphasize the importance of properly reporting all mishaps. As was the case in this incident, a pattern of minor mishaps will frequently reveal shortcomings in equipment, training, leadership and motivation that can lead to a major mishap. Had these minor mishaps been properly reported, and had corrective measures been taken, this major mishap may have been avoided.

G. I find that the supply and maintenance of survival equipment at Station Niagara was inadequate.

I base this finding upon:

- The station crew's need to share Personal Protection Equipment instead of having the personal issue equipment from the approved outfit list.
- The failure to replace the strobe light battery during scheduled maintenance as was called for by the procedure card.
- The damage to the MK 79 "pen flare" launcher and its failure to operate.

Action: As a result of this finding I direct:

- Area Commanders to ensure anti-exposure garments (dry suits and prescribed undergarments) are provided to boat crews as personal issue in the first, fifth, ninth, thirteenth, and seventeenth districts, and to crews in other locations specified in the Rescue and Survival Systems Manual (COMDTINST M10470.1 series).
- Commanders, Commanding Officers and Officers in Charge with operational responsibility for small boats to review the management and execution of survival equipment maintenance. After such a review they shall implement procedures and apply such resources as are necessary to ensure conformance to established standards.

- Assistant Commandant for Operations to immediately implement changes to the MK 79 preventative maintenance system to include a method to ascertain whether the MK 79 tube can accept a flare cartridge.

H. I find that the experience levels for personnel associated with this mishap, both overall boatcrew experience and year-round Great Lakes operations experience, were inadequate.

I base this finding upon:

- The junior nature of the boat crew and numerous instances of poor judgment that contributed to the mishap. While the three qualified crewmen had demonstrated appropriate performance in order to earn certification, their numerous performance lapses in this mishap are indicative of inexperience and/or a lapse in judgment.
- The very junior Group communications watchstander (only six months assigned as a TC3) and his decision to not follow-up more on Station Niagara's initial request for assistance contacting CG214341.
- The XPO had served at only one other station previously, and that was in the Florida Keys.

Unit experience levels will always be a function of the available Coast Guard workforce and training infrastructure. Recognizing the inherent limitations in both these factors, specific attention is required to prepare our units involved in small boat operations and command centers to succeed as we establish a unit's billet structure and assign members for duty. This specific attention includes:

Ensuring unit billets are at the appropriate grade levels;
Ensuring assignments capitalize upon members' specialized training and expertise;
Longer actual tour lengths to permit members to gain regional and environmental experience in their AOR and with their unit's unique mix of missions.

Action: As a result of this finding I direct:

- The Assistant Commandants for Operations, Marine Safety & Environmental Protection, Human Resources and Systems to ensure that newly established billets at units with operational responsibility for small boats and coastal command & control centers are sufficiently senior to reflect the personnel experience and expertise required at these units, as well as ensure that the appropriate number of apprentice billets are present for personnel to achieve expected experience levels for subsequent assignment.
- The Assistant Commandant for Human Resources to take appropriate action, such as the establishment of the approved Operations Specialist (OS) Rating, to ensure that required personnel experience and expertise levels are provided to Group and District command centers. Except where service needs dictate otherwise, military watchstanding positions at Group and District command centers shall be converted to the OS rating.

- The Assistant Commandants for Operations, Marine Safety & Environmental Protection, Human Resources and Systems to ensure that members assigned to boat crew billets are able to reuse and improve the skill sets they obtain. This shall be done by examining and defining the many advanced skill sets and qualification requirements required for boat crew positions (e.g., surfman, fastboat/tactical coxswain, station ops, ATON ops, TACLET/LEDET boarding officer, fisheries boarding officer, cutter operations, marine safety office duties, etc).
- The Assistant Commandant for Human Resources to, by 1 January 2003, develop an implementation plan for Boatswain's Mate career paths that provide for members to obtain and reuse a limited number of advanced skill sets (two or three) throughout their career.
- The Assistant Commandant for Human Resources to investigate and implement methods to increase the average length of assignments to match those published in the Personnel Manual. Investigate, and implement if feasible, longer assignment lengths and increased geographic stability.
- The Assistant Commandant for Human Resources to ensure that a unit's experience and expertise mix is a primary consideration in the personnel transfer and assignment process. Experience in AOR, mission, and assets (boats, aircraft, etc.) shall all be considered.

I. Finally, I find that the support and short notice response the Coast Guard received from RCC Trenton, the Erie County Sheriff, and the Lewiston and Wilson Fire Departments, was absolutely superior. Had it not been for their stalwart efforts, we may have lost all four of the crew members of CG-214341 that night. They have my heartfelt appreciation.

4. Summary

In short, this tragedy was brought about through shortfalls in:

- Leadership – This mishap involved numerous disconnects between policy and practice. These disconnects arose in every phase of the mishap from the maintenance of emergency signaling equipment several months before, to the wearing of personal protective equipment at the outset of the mission, to the speed and nature of response after our boat "went missing". Many of the errors made in this case involved Coast Guard members failing to adhere to policy and procedure and making a bad situation worse. Preventing this from occurring is a leadership issue that must be addressed by everyone in the chain of command - from a seaman on a boat crew to the Commandant.

- Training, Experience and Judgment – Adequate training that could have broken many of the links in this mishap chain was not available and/or the crew experienced lapses in judgment by not following the rules that could have kept them safe. I fully expect that

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the directives I have made as a result of this mishap and additional work force initiatives that Future Force 21 should develop will correct these shortcomings.

- Equipment – Much of the equipment involved in this mishap was inadequate in either quantity, quality, or both. While corrective actions for most all of the equipment issues associated with this case had already begun before the mishap, unfortunately their effects had yet to be felt by our boat crews. Funding to provide for a three year phase in of personal issue anti-exposure garments became available in FY-01. The National Distress and Response System Modernization Project is scheduled to include automated asset tracking and will be implemented completely by FY-06. Our effort to replace our wide variety of non-standard boats with a standard boat specifically selected for its ability to safely execute Coast Guard missions has been in process for several years and will begin to deliver boats later this year. This tragedy must reinforce the simple but extraordinarily important requirement that our crews be provided with complete, quality equipment across the entire spectrum of their needs.

We must all resolve to honor our lost crewmates with redoubled efforts to improve performance and eliminate the many shortfalls that led to this tragedy.

JAMES M. LOY

Exhibits: A – 170 enumerated Findings of Fact (may be released)
B – List of "redacted and withheld material" (may be released)
C – Enclosures to the Administrative Investigation (may be released)
D – Material exempted from release by the Freedom of Information Act

Dist: COMDT (G-CCS, G-O, G-W, G-S, G-M, G-L, G-SE, G-OC, G-OCS, G-OPR, G-WKS, G-WTT, G-SEN, G-LGL, G-LRA)
All Area and District Commanders
Commander, Coast Guard Group Buffalo, New York
Officer in Charge, Coast Guard Station Niagara